MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05400

Reg. Dist. No. 323

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about one month

Hospital, Institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ~~Md~~ Va. County Northampton

City or town ~~Salisbury Md~~

(If outside city or town limits, write RURAL and give nearest town)

Street No. no

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Mary Elizabeth Ayres

3.(b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	a.a.	married

6.(b) Name of husband or wife: Wenten Ayres

6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): about 1911

8. AGE: Years: about 33 | Months: — | Days: — | If less than one day: hrs. min.

8. Birthplace: Elizabeth City N.C.

(Town, county, and state)

10. Usual occupation: Housekeeping

11. Industry or business: Domestic duties

FATHER — 12. Name: Thomas Jenkins

13. Birthplace: New

MOTHER — 14. Maiden name: Mary Harris

15. Birthplace: Elizabeth City N.C.

16. Informant: Wenten Ayres

Address: Onley Va.

17. Burial, cremation, or removal. Which? Burial Date thereof: May 16-1945 (month) (day) (year)

Cemetery or crematory: Public Cem.

Location: Salisbury Md.

18. Funeral director: James D. Dunlap

Address: Salisbury Md

19. 5/16/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13, 1945, at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... to ... 19... and that I last saw him alive on ... 19...

Immediate cause of death: deceased

	DURATION
Due to: Pulmonary TBc	5 mo.
Due to:	
Other conditions: Not known	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ...

Means of injury: ... Injured at work?

23. SIGNATURE: G. K. Lemmon M.D. M. D. or other

Address: Salisbury Md Date signed: 5/16/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (562)

CERTIFICATE OF DEATH

05401

Reg. Diat. No. 333

1. PLACE OF DEATH:

County: Worcester

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Ocean City

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.

3.(a) FULL NAME Mary Baker

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	married

6.(b) Name of husband or wife: Denard Baker.

6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): January 30, 1903

8. AGE: Years	Months	Days	If less than one day
42	4	0	hrs. min.

9. Birthplace: Berlin Worcester Co. Md.

(Town, county, and state)

10. Usual occupation: Housewife.

11. Industry or business

FATHER 12. Name: William Powell

13. Birthplace: Maryland.

MOTHER 14. Maiden name: Mary Baker

15. Birthplace: Maryland

16. Informant: Mrs Denard Baker

Address: Ocean City Md

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) (day) (year) 6/2/45

Cemetery or crematory: Evergreen

Location: Berlin Md

18. Funeral director: Rena B. Burbage

Address: Berlin Md.

19. (Date rec'd by registrar) 6/2, 1945 Harriet D. Johnson Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 30, 1945; at 1:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 24 1945, to May 30 1945

and that I last saw h... alive on May 30 1945

Immediate cause of death	DURATION
Intestinal obstruction post op.	4 days
Due to	
Due to	
Other conditions: Fibroid Tumor of uterus	6 mos.

(Include pregnancy within 3 months of death)

Major findings of operations: Fibroid & multiple adhesions. Date of op. (5-25-45) (5-29-45)

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. A. Cashman M.D. M. D. or other

Address: Salisbury Md. Date signed 5/30/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

15402

Reg. Dist. No. 333

1. PLACE OF DEATH: Wicomico
County
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, Institution, or street address where death occurred: 404. Baker street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 404. Baker St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Sallie Jane Bedsworth

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	White	Married

6.(b) Name of husband or wife: George H. Bedsworth
6.(c) If alive, give age: 69 years
7. Birth date of deceased (mo., day, yr.): June 10-1878

8. AGE:

Years	Months	Days	If less than one day
66	10	24	hrs. min.

9. Birthplace: Quole Maryland (Town, county, and state)
10. Usual occupation: Home wife
11. Industry or business: at Home

FATHER
12. Name: Isaac Windsor
13. Birthplace: Somerset Co. Md.

MOTHER
14. Maiden name: Susan Ford
15. Birthplace: Somerset Co Md

16. Informant: Mr. Geo. H. Bedsworth
Address: 404. Baker st. Salisbury Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof May 7-1945 (month) (day) (year)
Cemetery or crematory: Quole Cem.
Location: Quole Maryland

18. Funeral director: Hollomon & Walter R. Holloman
Address: Salisbury Maryland

19. 5-7-1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 4th 1945 at 9.30 a.m. P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1945, to May 4 1945
and that I last saw h. alive on May 3 1945

Immediate cause of death	DURATION
Acute cardiac failure	
Due to Chronic Myocarditis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: M. D. or other
Address: Date signed 5-6-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05403

Reg. Diat. No. 331

1. PLACE OF DEATH:
County: Wicomico
City or town: Hebron md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 years
Hospital, Institution, or street address where death occurred: no
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Hebron
(If outside city or town limits, write RURAL and give nearest town)
Street No.: no
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME: Hester Buckhead

3.(b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	A.A.	widow

6.(b) Name of husband or wife: Samuel Buckhead
6.(c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.): about 1877

8. AGE: Years	Months	Days	If less than one day
about 68			....hrs. ....min.

9. Birthplace: Quantico md
(Town, county, and state)
10. Usual occupation: Housekeeper
11. Industry or business: Same as above
FATHER 12. Name: Unknown
13. Birthplace: Unknown
MOTHER 14. Maiden name: Unknown
15. Birthplace: Unknown
16. Informant: Jennie Gale
Address: Quantico md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/27/45 (month) (day) (year)
Cemetery or crematory: Parker walkins
Location: Parker walkins
18. Funeral director: James D. Stewart
Address: Salisbury Md
19. May 26 1945 Mrs J. M. Wallace
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 24th 1945; at 10.06 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1945, to May 23 1945
and that I last saw h... alive on May 23- 1945

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to	
Due to	
Other conditions: Chronic Nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: William Emrich M. D. or other
Address: Hebron Md Date signed: May 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of age of deceased is shown on FILM No. C 95 JUN 16 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (49)

CERTIFICATE OF DEATH

(3414)

Reg. Dist. No. 337

1. PLACE OF DEATH:
County: Baltimore
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Baltimore
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Ruth Lee Brewington

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Carl Ray Brewington
(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): Aug. 22 1889

8. AGE: Years	Months	Days	If less than one day
55 56	9		hrs. min.

9. Birthplace: Baltimore Md.
(Town, county, and state)

10. Usual occupation:
11. Industry or business: W.C. Welfare Board

FATHER
12. Name: Cornelius B. Mussina
13. Birthplace: Baltimore Md.

MOTHER
14. Maiden name: Hattie Fahnestock
15. Birthplace: Baltimore Md.

16. Informant: Mrs. Etha E. Dayton
Address: Rising Sun Lane Mount Ry. D.C.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: May 24 1945 (month) (day) (year)
Cemetery or crematory: Baltimore M. Church Cem.
Location: Baltimore Maryland.

19. Funeral director: C.G. Murdock
Address: Baltimore Md.

19. May 26 1945 R. Woolford Walter
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 22nd 1945 at 5:45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 22 1944 to May 22 1945 and that I last saw h... alive on May 22 1945

Immediate cause of death	DURATION
(a) Ca. of Left Ovary	1wk
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other
Address: Baltimore Date signed: 5/29/45

VS A15

PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 333

File 5405

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

Street No. 310 Second
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Edward Cook.

3.(b) Social Security Number: na

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	C	Single

6.(b) Name of husband or wife: no

no 6.(c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.): 8-19-44

8. AGE: Years	Months	Days	If less than one day
	8	27	hrs. min.

9. Birthplace: Salisbury Md
(Town, county, and state)

10. Usual occupation: no

11. Industry or business: no

FATHER 12. Name: Isaac Cook

13. Birthplace: Wellington Md

MOTHER 14. Maiden name: Mrs Lola James

15. Birthplace: Newton Md

16. Informant: Isaac Cook

Address: Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 18-1945
(month) (day) (year)

Cemetery or crematory: Oddfellows

Location: Wellington Md

18. Funeral director: James Stewart

Address: Salisbury Md

19. 5/18/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 18- 1945, at 10 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-16 1945, to 5-17 1945

and that I last saw him alive on 5-17 1945

Immediate cause of death: Infections Disease	DURATION ?
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: no

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. R. Wanner M.D.
M. D. or other

Address: Salisbury Md. Date signed 5-17-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

T 05406

Reg. Dist. No. 233

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Two years

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? Three weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Fruitland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: no
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: Charles Covington

3. (b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Lula M. Covington

6.(c) If alive, give age: yes years

7. Birth date of deceased (mo., day, yr.):

8. AGE: Years | Months | Days | If less than one day: hrs. min.

9. Birthplace: Snow Hill Md
(Town, county, and state)

10. Usual occupation: Minister

11. Industry or business: Same as above

FATHER 12. Name: Robert Covington

FATHER 13. Birthplace: Snow Hill Md

MOTHER 14. Maiden name: Nancy Covington

MOTHER 15. Birthplace: Snow Hill Md

16. Informant: Mrs Lula Covington

Address: Fruitland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 31 1945 (month) (day) (year)

Cemetery or crematory: Ebenezer

Location: Snow Hill Md

18. Funeral director: James D. Stewart

Address: Salisbury Md

19. 5/31/45 (Date rec'd by registrar) Margaret E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 26 1945, at 6 18 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/5 1945, to 5/26 1945

and that I last saw h alive on 5/26 1945

Immediate cause of death	DURATION
Cerebral vascular disease	2 years 2 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Edna T. Fisher nurse
M. D. or other

Address: Salisbury md Date signed: 5-29-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

175407

Reg. Dist. No. 393

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 mo 19 days
Hospital, institution, or street address where death occurred:
Welfare Home.
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County: Wicomico
City or town: Willard's
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: William H. Davis

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: ✓

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Dec. 7 1861

8. AGE: Years: ~~About 75~~ | Months: 4 | Days: 11 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Md., Wic. Willards
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: —

FATHER — 12. Name: Samuel D. Davis
13. Birthplace: Md.

MOTHER — 14. Maiden name: ~~Hearn~~ Rhoda Lewis
15. Birthplace: Md.

16. Informant: Myrtle Timmons
Address: Willards, Md.

17. Burial (Burial, cremation, or removal? Which?) Date thereof 5/20/1946 (month) (day) (year)

Cemetery or crematory: Quill Cemetery

Location: Wic. Willards Md.

18. Funeral director: M. Pasha Walton

Address: Salisbury, Md.

19. 5/20/1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 18 1946, at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1946, to May 18 1946 and that I last saw him alive on May 18 1946

Immediate cause of death	DURATION
Coronary Thrombosis	2 hrs
Due to: Chr. Hyp. Nephritis	1 yr
Due to: Arter. Sclerosis	2 yrs
Other conditions: Broncho Pneumonia	10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE: W. D. Davis M. D.
M. D. or other
Address: Pittsville, Md. Date signed 5/18/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

T 15408

Reg. Diat. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH. County: Wicomico — City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town) — How long in above place of death? 3 years — Hospital, institution, or street address where death occurred: 103 Lafayette Street — How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) — State: Md. — County: Wicomico — City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town) — Street No.: 103 Lafayette Street (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Annie Bell Dennis

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: E. Philander D. Dennis — 6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): Sept. 11- 1876

8. AGE: Years: 68 — Months: 8 — Days: 3 — If less than one day: hrs. min.

9. Birthplace: Wicomico Co. Md. (Town, county, and state)

10. Usual occupation: Home wife

11. Industry or business: at Home

FATHER — 12. Name: Johny Waddock — 13. Birthplace: Whitesville Delaware

MOTHER — 14. Maiden name: Jane Smack — 15. Birthplace: Whitesville Md.

16. Informant: Mrs. Elsa Messick — Address: 103 Lafayette st. Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) — Date thereof: May 17-1945 (month) (day) (year)

Cemetery or crematory: Mount Brooke Cem. — Location: near Parsonsburg Md

18. Funeral director: Holloway & Wallace Holloway — Address: Salisbury Maryland.

19. 5/16 1945 (Date rec'd by registrar) — Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 14th 1945 at 10.15P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 20 1945 to May 14 1945 and that I last saw her alive on May 14 1945

Immediate cause of death	DURATION
Valvular Heart Disease	6 yrs
Due to	
Due to	
Other conditions: Long standing case of pat Th (Include pregnancy within 3 months of death)	

Major findings of operations: — Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: — Injured at work?

23. SIGNATURE: Grace R. Means M. D. or other

Address: Salisbury Md — Date signed: 5/15/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

T 05499

Reg. Dist. No. 321

1. PLACE OF DEATH

County Wicomico

City or town Nelson Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Nelson Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Charles Edward Dickerson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	C.	Married

6.(b) Name of husband or wife Rosa Cook Dickerson

6.(c) If alive, give age 39 years

7. Birth date of deceased (mo., day, yr.) October 24 1903

8. AGE:

Years	Months	Days	If less than one day
41	6	27	....hrs. ....min.

9. Birthplace Nelson, Wicomico, Md.
(Town, county, and state)

10. Usual occupation Farming

11. Industry or business

FATHER
12. Name Oliver Dickerson
13. Birthplace Nelson, Md.

MOTHER
14. Maiden name Mary Bussing
15. Birthplace Salisbury, Md.

16. Informant Clifton Dickerson
Address Nelson, Md.

17. Burial Date thereof 5/24/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Maddela Cem.

Location Maddela, Md.

18. Funeral director David L. Messick

Address Nelson, Md.

19. May 24 1945 Mrs J. M. Wallace
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 21, 1945, at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 14 1945 to May 20 1945 and that I last saw h.. alive on May 20 1945

Immediate cause of death	DURATION
Coronary Thrombosis	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William Emrich M. D. or other

Address Nelson, Md Date signed May 22nd 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

05410

Reg. Dist. No. 339

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 week
Hospital, institution, or street address where death occurred: P. H. Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Wicomico
City or town: Parsonsburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Alma Willing Ennis

3.(b) Social Security Number:

4. Sex: Female
5. Color or race: white
6.(a) Single, married, widowed or divorced: Married
8.(b) Name of husband or wife: Lurge W. Ennis
8.(c) If alive, give age: 61 years
7. Birth date of deceased (mo., day, yr.): Sept 17, 1897
8. AGE: Years: 47 Months: 8 Days: 16 If less than one day: hrs. min.
9. Birthplace: Tyaskin Wicomico, Md (Town, county, and state)
10. Usual occupation: at home
11. Industry or business:
FATHER 12. Name: Ernest Willing
13. Birthplace: Tyaskin, Md
MOTHER 14. Maiden name: Anna Davis
15. Birthplace: Tyaskin Md
16. Informant: Lurge W. Ennis
Address: Salisbury, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-25-45 (month) (day) (year)
Cemetery or crematory: Methodist cemetery
Location: Parsonsburg Md
18. Funeral director: The Hill & Johnson co
Address: Salisbury, Md
19. 5/26/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 23 1945 at 8:20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 17 1945 to May 23 1945
and that I last saw him alive on May 23 1945

	DURATION
Immediate cause of death: Heart myocarditis	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. M. Dean M. D. or other
Address: Salisbury Md Date signed 5/25/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

05411

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

Reg. Dist. No. 333

VS A15 — MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, institution, or street address where death occurred: 206 Winder street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No. 206 Winder street, (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Stella Lee Farlow

3.(b) Social Security Number

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Linwood B. Farlow

6.(c) If alive, give age 42 years

7. Birth date of deceased (mo., day, yr.) June 30 - 1903

8. AGE: Years 41 Months 10 Days 9 If less than one day ... hrs. ... min.

9. Birthplace: Siloam Md. (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business: at Home

FATHER 12. Name: John S. Townsend

13. Birthplace: Siloam Md.

MOTHER 14. Maiden name: Eva Phillips

15. Birthplace: White Haven Md.

16. Informant: Mr. Linwood B. Farlow

Address: 206 Winder St. Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 12 45 (month) (day) (year)

Cemetery or crematory: Siloam Church Cem.

Location: Siloam Md.

18. Funeral director: Holloway & Co. Walter R. Holloway

Address: Salisbury Maryland

19. 5/12/ 1945 Harriet E. Johnson Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 9th 1945, at 2 40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ... no doctor I was notified

and that I last saw h... alive on ... 19 ...

Immediate cause of death: Carcinoma of left breast with metastasis generalized — DURATION: 2 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations: not known.

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: [signature] Deputy Med Exam MD — M. D. or other

Address: Salisbury Md. Date signed 5/10/45

Mr. Senter

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15)

CERTIFICATE OF DEATH

05412

Reg. Dist. No. 338

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Sharptown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Baby Boy Fletcher

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years	Months	Days	If less than one day
			3 hrs. 20 min.

9. Birthplace (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: Elvan Fletcher Jr

FATHER — 13. Birthplace: Del

MOTHER — 14. Maiden name: Margaret Bennett

MOTHER — 15. Birthplace: Md

16. Informant

Address: Sharptown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5—22—1945 (month) (day) (year)

Cemetery or crematory: Taylor's

Location: Sharptown

18. Funeral director: Graveno Bros.

Address: Sharptown Md.

19. 5/22/1945 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 21, 1945, at 1:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 21 1945 to May 21 1945

and that I last saw h... alive on ..... 19....

Immediate cause of death	DURATION
Premature (6 mos)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: H. E. Lpdates M. D. or ~~other~~

Address: Delmar Del Date signed: 5/23/1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170a

CERTIFICATE OF DEATH

T 05413

Reg. Dist. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town near Fruitland Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 days
Hospital, institution, or street address where death occurred:
P.R.R. tracks
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.D. #2
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Carl Sirams

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Stella M. Sirams
6.(c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) Jan 16 - 1895

8. AGE: Years	Months	Days	If less than one day
50	3	21	hrs. min.

9. Birthplace R.D. Salisbury Md.
(Town, county, and state)
10. Usual occupation Truck Driver
11. Industry or business

FATHER
12. Name Lambert Sirams
13. Birthplace R.D. Salisbury Md

MOTHER
14. Maiden name Catherine Parsons
15. Birthplace Wicomico Co. Md.

16. Informant Mrs. Stella M. Sirams
Address R.D. #2 Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 9 45 (month) (day) (year)
Cemetery or crematory Parsons Cem.
Location Salisbury Md.

18. Funeral director Hollowell & Walter R. Waller
Address Salisbury Md.

19. 5/9 19 45 Harriet E. Johnson Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 7th 19 45 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Compound Fractured skull	Sudden death
Due to	
Due to	
Other conditions Multiple fractures bones thrust body	

(Include pregnancy within 3 months of death)

Major findings of operations None
Date of op.
Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: yes
Accident, suicide, or homicide Accident Date of 5-7-45
Where did injury occur? Pocomoke Wicomico Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Highway
Means of injury Truck struck by train Injured at work? yes

23. SIGNATURE Deputy Medical Examiner
M. D. or other
Address Salisbury Md Date signed 5/8/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-0)

CERTIFICATE OF DEATH

05414 Reg. Dist. No. 335

1. PLACE OF DEATH:
County: Wicomico
City or town: Sharptown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 Years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wicomico
City or town: Sharptown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME George W. Footer — **3.(b) Social Security Number**

4. Sex: M
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed
6.(b) Name of husband or wife: Sallie Footer
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): August 4, 1859
8. AGE: Years: 85 | Months: 9 | Days: 10 | If less than one day: hrs. min.
9. Birthplace: Sussex Co Del (Town, county, and state)
10. Usual occupation: Retired Ship Carpenter
11. Industry or business:

FATHER
12. Name: Griffith Footer
13. Birthplace: Del

MOTHER
14. Maiden name: Olivia Burn
15. Birthplace: Del

16. Informant: Mrs Fannie Griffith
Address: Sharptown
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-17-1945 (month) (day) (year)
Cemetery or crematory: Taylor
Location: Sharptown
18. Funeral director: Gropengr Bros
Address: Sharptown Md
19. 5-23-15 1945 (Date rec'd by registrar) Walter H. Mann Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 14 1945, at 7:40 P.M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942 19.. to May 14 1945
and that I last saw him alive on May 13 1945

	DURATION
Immediate cause of death: Chronic Valvular Disease	2
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. S. Kuhlman M. D. or other
Address: Sharptown Md Date signed: 5/23/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

T 05415

Reg. Dist. No. 333

1. PLACE OF DEATH: Wicomico
County ..... Salisbury
City or town ..... (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? ..... Lifetime
Hospital, institution, or street address where death occurred: 415 Bush Street
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State ..... Md. County ..... Wicomico
City or town ..... Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No. ..... 415 Bush Street (If rural, give LOCATION)
2.(a) If veteran, name war .....

3.(a) FULL NAME Theodore Ernest Holloway

3.(b) Social Security Number

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Gertrude M. Holloway
6.(c) If alive, give age ..... 73 years
7. Birth date of deceased (mo., day, yr.): Jan. 25-1868
8. AGE: Years 77 Months 3 Days 19 If less than one day ..... hrs. ..... min.
9. Birthplace: Salisbury Md. (Town, county, and state)
10. Usual occupation: Retired
11. Industry or business: State Employee
FATHER 12. Name: Daniel James Holloway
13. Birthplace: Wicomico Co. Md.
MOTHER 14. Maiden name: Gertrude Adkins
15. Birthplace: Wicomico Co. Md.
16. Informant: Mrs. Gertrude M. Holloway
Address: 415 Bush St. Salisbury Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 16-46 (month) (day) (year)
Cemetery or crematory: Parsons Cemetery
Location: Salisbury Md.
18. Funeral director: Holloway & Walley R. Holloway
Address: Salisbury Md.
19. 5-15-46 (Date rec'd by registrar) 19 ..... Maggie E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 14 19 45 at 3:45 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/11 1945 to 5/14 1945 and that I last saw h[illegible] alive on 5/14 1945

Immediate cause of death	DURATION
Apoplexy	5 days
Due to: Arteriosclerosis	
Due to: Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Elmer T. Fowler M.D. M. D. or other
Address Salisbury Md. Date signed 5/14/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age is shown on

FILM No. G 95 JUN 13 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

05416

Reg. Dist. No. 3-37

1. PLACE OF DEATH:
County Wicomico Co.
City or town Nanticoke
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Sept since
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Wicomico
City or town Nanticoke
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Roy Horsman

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 15, 1884

8. AGE: Years	Months	Days	If less than one day
60	8	11	hrs. min.

9. Birthplace Bivalve, Md. (Town, county, and state)
10. Usual occupation Sailor
11. Industry or business

FATHER
12. Name Jackson Horsman
13. Birthplace Bivalve, Md.

MOTHER
14. Maiden name Sarah Horsman
15. Birthplace Bivalve, Md.

16. Informant Mrs. Geo. L. Horsman
Address Jesterville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 28-1945 (month) (day) (year)
Cemetery or crematory Oak Grove Cem.
Location Jesterville, Md.

18. Funeral director L. P. Measuches
Address Bivalve, Md.

19. May 29 1945 (Date rec'd by registrar) R. Walford Mallett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 26th 1945; at Last Known M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 25 1945 to May 26 1945
and that I last saw h... alive on May 25 1945

Immediate cause of death	DURATION
Coronary Thrombosis	24 hr.
Due to	
Due to	
Other conditions	

(Includo pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE D Allen Tull M. D. or other
Address Nanticoke Md Date signed 5-26-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charlea St., Baltimore 159

05417

CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Virginia County Accomac

City or town Bloxom
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME James

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) April 30, 1945

8. AGE: Years | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Salisbury, Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Thomas James

13. Birthplace

MOTHER 14. Maiden name Bessie Marie Mitchell

15. Birthplace Bloxom, Va.

16. Informant Mrs. Maude Hankins

Address 304 N. Division St. Salisbury

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 2, 1945 (month) (day) (year)

Cemetery or crematory Modest Town Cem

Location Modest Town, Del

18. Funeral director J. D. Johnson Jr.

Address Parksley, Va.

19. 5-1-45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 1, 1945, at 3:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Due to Premature	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lewis A. Lee M. D. or other

Address Salisbury, Md. Date signed 5-1-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (370)

05418

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 Days
Hospital, Institution, or street address where death occurred: 0
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Stockton
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION) 70
2.(a) If veteran, name war

3. (a) FULL NAME: Charles W. Jones

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Bettie H. Jones
6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.): May 29 - 1872

8. AGE: Years	Months	Days	If less than one day
72	11	13	hrs. min.

9. Birthplace: Stockton Worcester Md
(Town, county, and state)
10. Usual occupation: Waterman
11. Industry or business: Pinehurst Bay
FATHER 12. Name: Julius P. Jones
13. Birthplace: Maryland
MOTHER 14. Maiden name: Eliza Hayne
15. Birthplace: Maryland
16. Informant: Mrs. Hardy Hall
Address: Hallwood Virginia
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 13/45 (month) (day) (year)
Cemetery or crematory: Presbyterian
Location: Stockton, Md
18. Funeral director: Pearse & Dennis
Address: Snow Hill, Md
19. 5/13/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 11 1945, at 3:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1945, to May 11 1945
and that I last saw h alive on 5/11/45

Immediate cause of death	DURATION
1 Hypertension Arterio Sclerosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: Hypertension Arteriosclerosis
Date of op. 5/13/45
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: W. C. Neal M. D. or other
Address: Salisbury Date signed 5/13/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18a)

CERTIFICATE OF DEATH

(F541)

Reg. Dist. No. 339

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 weeks

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 7 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)

Street No. 803 Poplar Hill Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lankford-Mrs. Minnie Gertrude

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife B. N. Lankford

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 28, 1866.

8. AGE: Years 78 | Months 4 | Days 8 | If less than one day ..... hrs. ..... min.

9. Birthplace Pittsville, Wicomico, Md.
(Town, county, and state)

10. Usual occupation At Home

11. Industry or business

FATHER — 12. Name Joseph C. Rogers

13. Birthplace Pittsville, Md.

MOTHER — 14. Maiden name Rebecca Davis

15. Birthplace Pittsville, Md.

16. Informant Mrs. Charles E. Lankford

Address Salisbury, Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof 5/8/45. (month) (day) (year)

Cemetery or crematory Pittsville Methodist

Location Pittsville, Wicomico Co., Md.

18. Funeral director The Wilkinson Co.,

Address Salisbury, Md.

19. 5/5/45 (Date rec'd by registrar) Carrie L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 6 19 45 at 11 a. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... to ..... 19..

and that I last saw ... alive on ... 19..

Immediate cause of death	DURATION
Fractured Rt Hip	7 weeks
Due to	
Due to	
Other conditions Hemiplegia, edema of back	4 weeks

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 3-10-45

Where did injury occur? Salisbury (City or town) Wicomico (County) Md. (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Fell down Injured at work? No

23. SIGNATURE Deputy Med Examiner
M. D. or other

Address Salisbury Md. Date signed 4/16/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (42)

CERTIFICATE OF DEATH

05420

Reg. Dist. No. 337

1. PLACE OF DEATH:
County: Wicomico
City or town: Fruitland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Fruitland
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Elizabeth Larmore

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	—

6.(b) Name of husband or wife: Charles Larmore
6.(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): Jan. 24 1876

8. AGE: Years	Months	Days	If less than one day
69	3	12	hrs. min.

9. Birthplace: Fruitland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Isaac Dorman
13. Birthplace: Fruitland, Md.

MOTHER
14. Maiden name: Ida Dickerson
15. Birthplace: —

16. Informant: Milton Larmore
Address: Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 8 1945 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Fruitland Church Cemetery

18. Funeral director: Mrs. L. E. Messick Adams
Address: Fruitland Md

19. MAY 8 1945 (Date rec'd by registrar) H. S. Rodford Waller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 6 1945 at 11:20 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1944, to May 6 1945 and that I last saw h. alive on August 30 1945.

Immediate cause of death	DURATION
Carcinoma of Rectum	1 yr.
Due to	
Due to	
Other conditions: Diabetes mellitus	4 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: no
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: L. A. Rademaker M. D.
M. D. or other
Address: Salisbury Md. Date signed: 5/7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

T 05421

Reg. Dist. No. 333

1. PLACE OF DEATH: County Wicomico; City or town Salisbury (If outside city or town limits, write RURAL and give nearest town); How long in above place of death? 50 years; Hospital, institution, or street address where death occurred: 311. Barclay street; How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State Md. County Wicomico; City or town Salisbury (If outside city or town limits, write RURAL and give nearest town); Street No. 311. Barclay street (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Sarah Elizabeth Lecates

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Silas S. Lecates

6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): July 26 1870

8. AGE: Years 74 Months 10 Days 4 If less than one day ... hrs. ... min.

9. Birthplace: Georgetown Delaware (Town, county, and state)

10. Usual occupation: Home wife

11. Industry or business: at Home

FATHER 12. Name: William Campbell

13. Birthplace: Georgetown Del.

MOTHER 14. Maiden name: Rebecca Parker

15. Birthplace: Pittsville Maryland

16. Informant: Mrs. Priscilla Pitts

Address: 311. Barclay st. Salisbury Md

17. Burial (Burial, cremation, or removal, which) Date thereof June 3-45 (month) (day) (year)

Cemetery or crematory: Bethel Church Cem.

Location: Waletons Maryland

16. Funeral director: Holloway & Walter R. Holloway

Address: Salisbury Maryland.

19. 6/2/45 (Date rec'd by registrar) Harriet E. Todd Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 30 1945, at 7.45a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1945 to May 26 1945 and that I last saw her alive on May 26 1945

Immediate cause of death	DURATION
Cardiac Decomp.	
Due to: Arteriosclerotic Heart Disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Jno. Lynch M. D. or other

Address: Salisbury Md. Date signed 5/31/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (53)

CERTIFICATE OF DEATH

05422

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 years
Hospital, institution, or street address where death occurred: 609 South Division St
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wicomico Co.
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 609 South Division St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Howard C. Livingston

3.(b) Social Security Number: 212-18-6005

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 7. 1914

8. AGE: Years	Months	Days	If less than one day
30	9	16	hrs. min.

9. Birthplace: Salisbury Wicomico Co. Md (Town, county, and state)
10. Usual occupation: Florist, Tusk Drive
11. Industry or business:

FATHER
12. Name: Radley W. Livingston
13. Birthplace: Wicomico Co. Md

MOTHER
14. Maiden name: Annie M. Brown
15. Birthplace: Wicomico Co. Md

16. Informant: Mrs Horace Culver
Address: Salisbury. Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof 5-21-45 (month) (day) (year)
Cemetery or crematory: Union Cemetery
Location: Near Salisbury Md
18. Funeral director: The Hill & Johnson Co.
Address: Salisbury Md

19. 5/25/45 (Date rec'd by registrar) 1945 Margaret E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 23 1945, at 10:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/10 1945 to 5/23 1945 and that I last saw h— alive on 5/23 1945

Immediate cause of death: Squamous Cell Carcinoma inguinal region, right — DURATION

Due to:

Due to:

Other conditions: None

(Include pregnancy within 3 months of death)

Major findings of operations: None — Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: P. Rivers Hanson, M.D. M. D. or other
Address: Salisbury, Md. Date signed: 5/25/45

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

05423

Reg. Dist. No. 337

1. PLACE OF DEATH:

County Wicomico

City or town Nanticoke (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Nanticoke (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Long, Preston

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	col.	Widower

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 10, 1891

8. AGE: Years	Months	Days	If less than one day
54	3	4	..... hrs. ..... min.

9. Birthplace Nanticoke (Town, county, and state)

10. Usual occupation Oysterman

11. Industry or business

FATHER 12. Name Charles Long

13. Birthplace Nanticoke

MOTHER 14. Maiden name Don't know

15. Birthplace "

16. Informant Theodore Long

Address 1200 Mt. Elderry Court Baltimore, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 9 1945 (month) (day) (year)

Cemetery or crematory Cemetery

Location Nanticoke

18. Funeral director Mrs. Ed Messick & Sons

Address Pittsville, Md.

19. Mar 9 1945 (Date rec'd by registrar) R. Telford Wal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-6 1945, at 11 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... to ..... 19.....

and that I last saw him alive on ..... 19.....

Immediate cause of death ..... DURATION

Coronary Thrombosis ..... Sudden death

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. .....

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. A. Rademaker M.D. Deputy Medical Examiner M. D. or other

Address Salisbury, Md. Date signed 5/6/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (100-a)

CERTIFICATE OF DEATH

115424

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury Rural
(If ontside city or town limits, write RURAL and give nearest town)

How long in above place ot death? 4 days

Hospital, Institution, or street address where death occurred:
E.S. VB Sanatorium

How long in hospital or Institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Stockton
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Harvey Lee Lynch

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Mrs. Alice Lynch

6.(c) If alive, give age: 36 years

7. Birth date of deceased (mo., day, yr.): July 7, 1903

8. AGE:

Years	Months	Days	If less than one day
41	10	14	hrs. min.

9. Birthplace: Princess Anne Virginia
(Town, county, and state)

10. Usual occupation: waterman

11. Industry or business:

FATHER
12. Name: Elva Lynch
13. Birthplace: unknown

MOTHER
14. Maiden name: Mathilda Jester
15. Birthplace: Virginia

16. Informant: deceased on admission
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/23/45 (month) (day) (year)
Cemetery or crematory: Taylorville
Location: Berlin R F D

18. Funeral director: Anna A Burbage
Address: Berlin, Md

19. 5/23/45 (Date rec'd by registrar) Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 21 1945 at 11:25 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/17/45 19.. to 5/21/45 19.. and that I last saw him alive on 5/21/45 19..

Immediate cause of death	DURATION
Brain Embolism	1 day
Cardiac Embolism	3 days
Due to Pulmonary Embolism	2 wks.
Due to Hemorrhoidectomy with multiple thrombi	2 mos.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Paul Quinn M.D.
M. D. or other
Address: Salisbury Md Date signed 5/21/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of age is shown on FILM No. G-95 JUN 13 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

T 05425

Reg. Diat. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution or street address where death occurred: P. B. Hoyt.
How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Pittsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D. #2
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Frank Marasco

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Erminia Marasco
6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): Aug. 22-1889

8. AGE: Years	Months	Days	If less than one day
55 ~~56~~	9	23	hrs. min.

9. Birthplace: Italy (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:

FATHER
12. Name: Angelo Marasco
13. Birthplace: Italy

MOTHER
14. Maiden name: Coronnia Gillette
15. Birthplace: Italy

16. Informant: Mrs. Erminia Marasco
Address: R.D. #2 Pittsville Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 18-45 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Maryland.
18. Funeral director: Hellens & Co. Walter R. Hellens
Address: Delmar Md.

19. 5/18/45 (Date rec'd by registrar) Maggie E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 15th 1945 at 9:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 1945 to May 15 1945 and that I last saw h[illegible] alive on May 15 1945

	DURATION
Immediate cause of death: Pulmonary Embolism	
Due to: Hypertensive Vascular Disease	Unk.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Hypertensive Vascular Disease Date of op. 5/11/45
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Date signed

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 55-2

CERTIFICATE OF DEATH

05426

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury 2nd

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. 315 Isabella St

(If rural, give LOCATION)

2.(a) If veteran, name war: C no

3.(a) FULL NAME: Michele Lakemia Matthews

3.(b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	a-a	Single

6.(b) Name of husband or wife: no

6.(c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.): Feb. 9 1943

8. AGE: Years: 2 Months: 3 Days: 9 If less than one day: hrs. min.

9. Birthplace: Salisbury Md (Town, county, and state)

10. Usual occupation: no

11. Industry or business: no

MOTHER

12. Name: James R Matthews

13. Birthplace: Philadelphia

FATHER

14. Maiden name: Thelma Hatton

15. Birthplace: Salisbury Md

16. Informant: James R Matthews

Address: Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 21 - 1945 (month) (day) (year)

Cemetery or crematory: Hanson

Location: Salisbury Md

18. Funeral director: James L Stewart

Address: Salisbury

19. 5/20/45 (Date rec'd by registrar) Harriet E Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5-18 1945 at 4.25 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-1 1945, to 5-18 1945 and that I last saw h.. alive on 5-17-45 1945

Immediate cause of death: C.N.S. tissue destruction

DURATION

Due to: Tumor (retina) Glastoma of left eye) from birth

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: E. A. Purnell M.D. M. D. or other

Address: 620 W. main St. Salisbury Date signed: 5-18-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (53-0)

CERTIFICATE OF DEATH

05427

Reg. Dist. No. 223

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County: Wicomico
City or town: Parsonsburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 years
Hospital, institution, or street address where death occurred: R.D. #2
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Parsonsburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. R.D. #2
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Joseph John McAllister

3.(b) Social Security Number:

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widower
6.(b) Name of husband or wife: Laura A. McAllister
6.(c) If alive, give age: Dead years
7. Birth date of deceased (mo., day, yr.): May 30-1869
8. AGE: Years: 75 Months: 11 Days: 29 If less than one day: hrs. min.
9. Birthplace: Sussex Co. Del. (Town, county, and state)
10. Usual occupation: Retired Farmer
11. Industry or business:
FATHER 12. Name: Greenbury McAllister
13. Birthplace: Sussex Co. Del.
MOTHER 14. Maiden name: Eliza Jane Baker
15. Birthplace: Worcester Co. Md.
16. Informant: Mrs. Wallace Lokey
Address: 314 Charles St. Salisbury Md.
17. Buried (Burial, cremation, or removal. Which?) Date thereof May 31-45 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Maryland
18. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Maryland.
19. 5/31/45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 29th 1945 at 1:45 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 25 1945 to May 29 1945
and that I last saw him alive on May 25 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	
Due to: Hypertension	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Salisbury Md. Date signed: 5/31/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 89-a

CERTIFICATE OF DEATH

65428

Reg. Dist. No. 339

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? six weeks
Hospital, institution, or street address where death occurred:
Mrs Lemon's (Home)
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Dorchester
City or town Lakesville
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rural
(If rural, give LOCATION)
2.(a) If veteran, name war X ✓

3.(a) FULL NAME ERNEST H. MCNAMARA.

3.(b) Social Security Number X

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Eliza Phillips
Deceased 6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) 1869

8. AGE: Years	Months	Days	If less than one day
76			..... hrs. ..... min.

9. Birthplace Lakesville (Dor. Co.) Md.
(Town, county, and state)
10. Usual occupation Waterman
11. Industry or business X

FATHER
12. Name Jerome McNamara
13. Birthplace Md.

MOTHER
14. Maiden name Carnelia Mister
15. Birthplace Md.

16. Informant Robert Christopher
Address Cambridge, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/29/45 (month) (day) (year)
Cemetery or crematory Family
Location Lakesville, Md.

18. Funeral director LeCompte Funeral Service
Address Cambridge, Maryland.

19. 5/29 19 45 Harriet E. Johnson Local Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 19 45 at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 45 to May 26 19 45
and that I last saw h... alive on May 26 19 45

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE M. D. or other
Address Salisbury Md. Date signed 5/28/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-7)

CERTIFICATE OF DEATH

05429

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Wicomico Co.
City or town: Salisbury Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 2 mo. 21 d.
Hospital, Institution, or street address where death occurred:
E. S. T.B. Sanatorium
How long in hospital or institution? 1 yr. 2 mo. 21 d.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Chester town
(If outside city or town limits, write RURAL and give nearest town)
Street No. 114 Cannon St
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Charles Walter Mench

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Violet L Mench
6.(c) If alive, give age: 26 years

7. Birth date of deceased (mo., day, yr.): Oct 27, 1915

8. AGE: Years	Months	Days	If less than one day
29	6	10	...hrs. ...min.

9. Birthplace: Kent Co., Maryland (Town, county, and state)
10. Usual occupation: Foreman
11. Industry or business: Powder Factory
FATHER 12. Name: Horace W. Mench
13. Birthplace: Maryland
MOTHER 14. Maiden name: Mary E. White
15. Birthplace: Maryland
16. Informant: deceased (on admission)
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 5/10/45 (month) (day) (year)
Cemetery or crematory: Chester Town, Md.
Location: Chestertown, Md.
18. Funeral director: Edgar L. Sauer
Address: Church St. Ellis, Md.
19. 5/10/45 (Date rec'd by registrar) Carrie L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 7 1945, at 7.54 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/16/44 19... to 5/7/45 19...
and that I last saw h...alive on 5/7/45 19...

Immediate cause of death	DURATION
T.B. meningitis	3 wks.
Due to: Pulmonary Tuberculosis	19 mo.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Paul Cohen M. D.
M. D. or other
Address: Salisbury Md. Date signed 5/8/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

CERTIFICATE OF DEATH

T 05430

Reg. Dist. No. 331

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Delmar (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Delmar (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Doreen Jean Morris

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F.	C.	

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 7, 1944

8. AGE: Years	Months	Days	If less than one day
	8	6	hrs. min.

9. Birthplace Delmar, Wicomico, Md. (Town, county, and state)
10. Usual occupation
11. Industry or business

FATHER
12. Name Harlan Morris
13. Birthplace Delmar Md.

MOTHER
14. Maiden name Julia Fider
15. Birthplace Wicomico Md.

16. Informant Julia Morris
Address Delmar Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/14/45 (month) (day) (year)
Cemetery or crematory Evergreen Cem.
Location Wicomico Co. Md.

18. Funeral director David K. Messick
Address Delmar, Md.

19. May 14 1945 Mrs J M. Walker
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 13, 1945 at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Office visit 19 May 5 45 19
and that I last saw h alive on May 5 45 19

Immediate cause of death Pneumonia

	DURATION
Due to Visited my office 5/5/45 and had Acute Bronchitis	
Due to	
Other conditions Measles	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Lewis R Morris M. D. or other
Address Delmar Md Date signed 5/14/45

Dr. Mann

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

05431

Reg. Dist. No. 933

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred: 516 Washington St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No. 516 Washington St. (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Millie Katie Parker

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: John A. Parker
6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): Nov. 11 - 1876

8. AGE:	Years	Months	Days	If less than one day
	68	5	24	hrs. min.

9. Birthplace: R.D. Salisbury Md. (Town, county, and state)
10. Usual occupation: Home / wife at Home
11. Industry or business:

FATHER
12. Name: Daniel Betts
13. Birthplace: R.D. Salisbury Md

MOTHER
14. Maiden name: Catherine Wyatt
15. Birthplace: Wicomico Co. Md.

16. Informant: Mrs. Florence Kelley
Address: 516 Washington St. Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 8-45 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Md
18. Funeral director: Hollopeter & Walter R. Holloway
Address: Salisbury Md.

19. 5/8/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 5th 19 45 at 6 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 43 to May 5 19 45
and that I last saw h[illegible] alive on May 3 19 45

Immediate cause of death	DURATION
Cerebral Hemorrhage Due to	Hours
Hypertension Due to	2 yrs.
Chronic Nephritis (Include pregnancy within 3 months of death)	Years

Other conditions:
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Steven R Mann
Address: Salisbury Md M. D. or other
Date signed: 5/6/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

STATE OF MARYLAND—CERTIFICATE OF DEATH

T 5432

(137-C)

1. PLACE OF DEATH

County Wicomico Registration Dist. No. 332

Village or City Willards, Md. No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Joanne Elizabeth Regnault If U. S. Veteran, specify WAR

(a) Residence: No. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
Female	White	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of George W. Regnault

6. DATE OF BIRTH (month, day, end year) June 18th 1860

7. AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	11	5	

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. House Work.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc. None

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Near Willards, Md. (State or country)

FATHER

13. NAME Benjamin Dennis

14. BIRTHPLACE (city or town) Willards (State or country) Md

MOTHER

15. MAIDEN NAME Mellie Dennis

16. BIRTHPLACE (city or town) Willards Md. (State or country)

17. INFORMANT Lawrence Dennis (Address) Willards, Md.

18. BURIAL, CREMATION, OR REMOVAL Place Burial Dennis G. Date May 25 19 45

19. UNDERTAKER Wm. Howard Wells (Address) Pittsville, Md.

20. FILED 5/25 1945 William R. Davis Registrar. Local

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH May (Month) 23 (Day) 1945 (Year)

22. I HEREBY CERTIFY, That I attended deceased from May 19 40 to May 23 19 45

I last saw her alive on 5/23 1945; deeth is seid to have occurred on the date steted above, at 330 P. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Chr. Nephritis	
Other Contributory Causes of importance:	

Neme of operetion Dete of

Whet test confirmed diagnosis? Was there en autopsy?

23. If deeth wes due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Menner of injury

Nature of Injury

24. Was diseese or injury in any way related to occupation of deceased?

If so, specify

(Signed) Chas. R. Lowe M. D.

(Address) Berlin Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-T)

CERTIFICATE OF DEATH

05433

Reg. Dist. No. 393

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury, Maryland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? from 2/7/45
Hospital, Institution, or street address where death occurred:
E. S. Tb. Sanatorium
How long in hospital or institution? from 2/7/45

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Caroline
City or town: Ridgely, Maryland (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war: No ✓

3.(a) FULL NAME: Arthur Charles Rockwell

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

8.(b) Name of husband or wife: Ethel Rockwell
8.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): April 5, 1886

8. AGE: Years	Months	Days	If less than one day
59	1	8	..... hrs. ..... min.

8. Birthplace: Preakness, N. J. (Town, county, and state)
10. Usual occupation: Filling Sta. Operator
11. Industry or business
FATHER 12. Name: Charles Mason Rockwell
FATHER 13. Birthplace: ~~Preakness~~ Wisconsin
MOTHER 14. Maiden name: Cristina Marion
MOTHER 15. Birthplace: Preakness, N. J.
16. Informant: deceased Chas. M. Frank Rockwell
Address: 156 Hobart Place, Totowa Boro. Paterson N. J.
17. Cremation (Burial, cremation, or removal. Which?) Date thereof May 16, 1945 (month) (day) (year)
Cemetery or crematory: Wm. Leis & Son
Location: Washington D. C.
18. Funeral director: Holloway & Co. Hunter Holloway
Address: 520 E. Church St. Salisbury, Md.
19. 5/15/45 (Date rec'd by registrar) Maggie E. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13, 1945, at 9 PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/7/45 to 5/13/45
and that I last saw him alive on 5/13/45

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	1 yr.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy? Results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury: ..... Injured at work?

29. SIGNATURE: Paul Cohen M.D. M. D. or other
Address: Salisbury, Maryland Date signed 5/14/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-A)

05434

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Somerset

City or town: Princess Anne

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mamie E. St. Clair

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	C	widow

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1877

8. AGE: Years 68 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: Princess Anne, Somerset Co., Md. (Town, county, and state)

10. Usual occupation: Hairdresser

11. Industry or business: "

FATHER 12. Name: Edward Hall

13. Birthplace: Somerset Co., Md.

MOTHER 14. Maiden name: Mary L. Waters

15. Birthplace: Somerset Co., Md.

16. Informant: Gwendolyn Dennis

Address: Princess Anne, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5 (month) 16 (day) 1945 (year)

Cemetery or crematory: Princess Anne Cem.

Location: Princess Anne, Md.

18. Funeral director: James E. Dennis

Address: Princess Anne, Md.

19. 5-3-45 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 3 1945, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 20 1945, to May 3 1945

and that I last saw h.e alive on May 3, 1945 19

Immediate cause of death	DURATION
Cardio-vascular renal disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Leslie E. Fuller M. D. or other

Address Date signed 5-3-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (43-d)

05435

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH: Wicomico
County ..... Salisbury
City or town ..... (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years
Hospital, Institution, or street address where death occurred: 115 Beauty Street
How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No. 115 Beauty street (If rural, give LOCATION)
2.(a) If veteran, name war .....

3. (a) FULL NAME John Frederick Schwartz — 3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Fowrie Schwartz
6.(c) If alive, give age 43 years
7. Birth date of deceased (mo., day, yr.) Feb. 9-1873

8. AGE:

Years	Months	Days	If less than one day
72	3	9	..... hrs. ..... min.

9. Birthplace Trenton N.J. (Town, county, and state)
10. Usual occupation Buck Mason
11. Industry or business .....
12. FATHER Name John Frederick Schwartz
13. FATHER Birthplace Trenton, N.J.
14. MOTHER Maiden name Maria Lucas
15. MOTHER Birthplace N.J.
16. Informant Mrs. Fowrie Schwartz
Address 115. Beauty st. Salisbury Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 20 45 (month) (day) (year)
Cemetery or crematory Episcopal Cem.
Location Princess Anne Md
18. Funeral director Holloway & Walter R. Holloway
Address Salisbury Maryland.
19. 5/20/45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 18th 1945 at 1.a M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-14 1945 to 5-17 1945
and that I last saw h.. l.. alive on 5-17- 1945

Immediate cause of death	DURATION
Acute cardiac failure	
Due to Chronic Myocarditis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?
23. SIGNATURE Floyd A. Insley M. D. or other
Address Salisbury Md Date signed 5-18-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

05436 Reg. Dist. No. 4336

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Wicomico

City or town Delmar

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 7 West Elizabeth

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 1 hr. 45 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Delmar Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 7 West Elizabeth

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Catherine Elizabeth Searcy

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 27 1945

8. AGE: Years | Months | Days | If less than one day: 1 hrs. 45 min.

9. Birthplace Delmar, Wicomico County (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name James F. Searcy

FATHER 13. Birthplace Birmingham, Alabama

MOTHER 14. Maiden name Katherine Elliott

MOTHER 15. Birthplace Delmar, Del

16. Informant James F. Searcy

Address Delmar, Del

17. Burial Date thereof 5-29-45

(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Mt. P.

Location Delmar, Delaware

18. Funeral director W. S. Hyland Co

Address Delmar, Del

19. May 29 1945 Harry E Hudson

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 1945, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 27 1945 to May 27 1945, and that I last saw h[illegible] alive on 19

Immediate cause of death	DURATION
(a) Suffocation (6 min.)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. E. Lecates M. D. or other

Address Delmar Date signed 5/29/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

not CB T 15437

Reg. Dist. No. 11336

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Hampden
City or town: Delmar
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 10 East St
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 3 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Mass. County: Berkshire
City or town: North Adams Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 33 Jordan Avenue
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: World War I

3. (a) FULL NAME: Harry Remington Shuntleff

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Divorced

6. (b) Name of husband or wife: Pauline Shuntleff
6. (c) If alive, give age: 40 years

7. Birth date of deceased (mo., day, yr.): Jan 4 - 1894

8. AGE: Years: 51 | Months: | Days: | If less than one day: hrs. min.

9. Birthplace: North Adams, Mass. (Town, county, and state)
10. Usual occupation: Painter
11. Industry or business: House
FATHER 12. Name: George A. Shuntleff
13. Birthplace: New York
MOTHER 14. Maiden name: Martha E. Burnie
15. Birthplace: Watervliet New York
16. Informant: Mrs Harry Shuntleff
Address: Delmar Del.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-21-45 (month) (day) (year)
Cemetery: South View
Location: North Adams, Mass.
18. Funeral Director: W. S. Hazel Co
Address: Delmar Delaware
19. 5-19 1945 (Date rec'd by registrar) Harry E. Hudson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 18th 1945, at 2:05 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 14 1945, to May 18 1945, and that I last saw him alive on May 17 1945.

Immediate cause of death	DURATION
Bronchial Asthma & coma	2 days
Due to Tuberculosis of Lungs	16 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. H. Lynch M. D. or other
Address: Delmar Del. Date signed: May 19 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17)

CERTIFICATE OF DEATH

05438

Reg. Dist. No. 233

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred: Fruitvale Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No.: P.O. Box 922 Fruitvale st (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Anna Katherine Smith

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Roland S. Smith
6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): Sept. 13. 1893

8. AGE: Years 51 | Months 7 | Days 26 | If less than one day: hrs. min.

9. Birthplace: Salisbury Maryland (Town, county, and state)
10. Usual occupation: Home wife
11. Industry or business: at Home

MOTHER
12. Name: Lenia Tindle
13. Birthplace: Salisbury Maryland

FATHER
14. Maiden name: Ida White
15. Birthplace: Salisbury Maryland

16. Informant: Mrs. Hunken Davis
Address: 413 Dilworth st. Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 12-45 (month) (day) (year)
Cemetery or crematory: Parsons Cemetery
Location: Salisbury Maryland.

18. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Maryland

19. 5/12/45 (Date rec'd by registrar) Barrett E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9th 1945 at 4 P. M

21. I CERTIFY, that death occurred on the date above stated: that I attended deceased from December 19 45 to Saw Patient Dead 19 45
and that I last saw h alive on December 9 19 45
Immediate cause of death (Enter only one cause per line for (a), (b), and (c).)

	DURATION
(a) Coronary Occlusion, Heart Failure, Marked Cyanosis	
Due to: Arteriosclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: C. Hearn M. D. or other
Address: 203 W. Church St. Date signed

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (167)

CERTIFICATE OF DEATH

05439

Reg. Diat. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury

(If ontside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 18 years

Hospital, institution, or street address where death occurred: no

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. Ford Street

(If rural, give LOCATION)

2.(a) If veteran, name war ns

3. (a) FULL NAME Spruill, George

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	a a	married

6.(b) Name of husband or wife Martha Spruill

6.(c) If alive, give age 44 years

7. Birth date of deceased (mo., day, yr.) about 1895

8. AGE: Years 50 | Months | Days | If less than one day ... hrs. ... min.

9. Birthplace Scotland Neck, North Carolina (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Same as above

FATHER 12. Name Robert Dixon

13. Birthplace Scotland Neck, North Carolina

MOTHER 14. Maiden name Dicie Spruill

15. Birthplace Scotland Neck, North Carolina

16. Informant Rev. Cornelius Spruill

Address Philadelphia, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof May 23 1945 (month) (day) (year)

Cemetery or crematory Houston

Location Salisbury Md

18. Funeral director James F. Stewart

Address 402 E. Church St. Salisbury Md

19. 5/23/45 (Date rec'd by registrar) Harriet P. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5-20 1945 at 6 p. m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw ... alive on ... 19...

Immediate cause of death	DURATION
multiple lacerations with severed jugular vein (a)	sudden death
Due to (b)	
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. ...

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: yes

Accident, suicide, or homicide Homicide Date of 5-20-45

Where did injury occur? Salisbury (City or town) Wicomico (County) Md (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Cut with axe Injured at work? no

by another

23. SIGNATURE Joseph Lademan MD

M. D. or other

Address Salisbury, Md Date signed 5/20/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (51a)

CERTIFICATE OF DEATH

1 0544733

Reg. Dist. No. 210

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution? 4 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Somerset
City or town: Crisfield
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Columbia Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war: none ✓

3.(a) FULL NAME: Delia A. Stevenson

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widow

6.(b) Name of husband or wife: Frederick C.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 15, 1871

8. AGE: Years	Months	Days	If less than one day
74	3	4	..... hrs. ..... min.

9. Birthplace: Glocester Co., Va.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: self

FATHER
12. Name: William Adams
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Julia A. Sparrow
15. Birthplace: Somerset Co., Md.

16. Informant: Ella Covington
Address: Pocomoke City, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/21/45 (month) (day) (year)
Cemetery or crematory: Crisfield Cemetery
Location: Crisfield, Md.

18. Funeral director: Howard H. Hubbard
Address: 306 Main St., Crisfield, Md.

19. 5/21/45 (Date rec'd by registrar) 19 ..... C. E. Collins, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 19, 1945 19..... 1.45 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 7 1945 to May 19 1945
and that I last saw h.... alive on May 19 1945

Immediate cause of death	DURATION
Chr. Interst. Nephritis	6 mos
Due to Chr. Int. Nephritis	1 yrs
Due to Arteriosclerosis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: W. O. Laing M.D.
M. D. or other
Address: Fruitland, Md. Date signed 5/21/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

!!5441

Reg. Dist. No. 3 27

1. PLACE OF DEATH:

County: Wicomico

City or town: White Haven, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: White Haven
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Nancy Emily Thomas

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	Col.	Married

6.(b) Name of husband or wife: Major Thomas

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 1869

8. AGE:

Years	Months	Days	If less than one day
76	about 7 mos.	unknown	hrs. ..... min.

9. Birthplace: White Haven
(Town, county, and state)

10. Usual occupation: House work

11. Industry or business: Own home

FATHER
12. Name: Samuel Wilson
13. Birthplace: Somerset Co.

MOTHER
14. Maiden name: Jane Evans
15. Birthplace: Hanticoke, Md.

16. Informant: Lone Thomas

Address: White Haven, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5/6/45 (month) (day) (year)

Cemetery or crematory: Clara Cemetery

Location: White Haven

18. Funeral director: Mrs. L. A. Messick & Sons

Address: Pocomoke Md

19. May 5 19 45 (Date rec'd by registrar) R. Wolford Walter Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 3 45 at 9 [illegible] M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 19 45, to May 3 19 45, and that I last saw h[illegible] alive on May 3 19

Immediate cause of death	DURATION
Pulmonary Tbc	2 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: D. Allen Fields M. D. or other

Address: Manokin Md Date signed 5-4-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

115442

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4/23/45
Hospital, Institution, or street address where death occurred:
E. S. Tb. Sanatorium
How long in hospital or institution? 4/23/45

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Stockton,
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Catherine Cornelia Townsend

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: George T. Townsend

8.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): March 26, 1882

8. AGE: Years	Months	Days	If less than one day
63	1	17	hrs. min.

9. Birthplace: Sanford, Va.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: William Henry Cutler
13. Birthplace: Virginia

MOTHER
14. Maiden name: Mary A. Hall
15. Birthplace: Virginia

16. Informant: Mr. George T. Townsend
Address: Stockton, Md

17. Burial
(Burial, cremation, or removal. Which?) Date thereof May 16/45 (month) (day) (year)
Cemetery or crematory: Nelson
Location: Hebronville City Md Rural

18. Funeral director: Pearne & Downing
Address: Snow Hill Md

19. 5/15/45 Harriet E. Johnson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 13 19 45 at 11:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/1/42 19 to 5/13/45 19 and that I last saw her alive on 5/13/45 19

Immediate cause of death	DURATION
Pulmonary Tuberculosis	4 yr
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Paul Owen M. D. or other
Address: Salisbury, Maryland Date signed: 5/13/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

05443

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Allen (If outside city or town limits, write RURAL and give nearest town)

Street No. no (If rural, give LOCATION) no

2.(a) If veteran, name war: no

3.(a) FULL NAME: Full, Samuel

3.(b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	widower

6.(b) Name of husband or wife: Leigh Full

6.(c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.): about 1867

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
about 78				

9. Birthplace: Allen md (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Same as above

FATHER — 12. Name: Samuel Full

FATHER — 13. Birthplace: Allen md

MOTHER — 14. Maiden name: Sarah Morris

MOTHER — 15. Birthplace: Allen md

16. Informant: Doris Polk

Address: Allen Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 30 1945 (month) (day) (year)

Cemetery or crematory: Friendship

Location: Allen md

18. Funeral director: James F. Stewart

Address: Salisbury md

19. 5-30-1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 27 1945, at 4-45 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 10 1945 to May 27 1945 and that I last saw him alive on May 27 1945

Immediate cause of death	DURATION
Chr. Valv Hrt.	2 yrs
Chr. Int. nephritis	3 yrs
Due to: Hypertension	4 yrs
Due to: Arter Sclerosis	6 yrs
Other conditions: Arthritis Deformans	10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. D. Davis M.D. M. D. or other

Address: Pittsville Date signed: 5-27-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

05445

Reg. Dist. No. 335

1. PLACE OF DEATH:
County: Charles
City or town: Charlotte
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Chas
City or town: Charlotte
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Curtis R. Vickers

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Married

6.(b) Name of husband or wife: Annie E. Vickers
6.(c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): Aug 19 1864

8. AGE: Years	Months	Days	If less than one day
80	9	19	hrs. min.

9. Birthplace: Dorchester Md (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business:
FATHER — 12. Name: John Vickers
13. Birthplace: Md
MOTHER — 14. Maiden name: Annie Calloway
15. Birthplace: Md
16. Informant: Annie E. Vickers
Address: Charlotte
17. Burial (Burial, cremation, or removal) Date thereof 5-30-1945 (mooth) (day) (year)
Cemetery or crematory: Galestown, Md
Location:
18. Funeral director: Spencer Bros
Address: Charlotte
18. 5-29 1945 (Date rec'd by registrar) Walter G. Mann Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 5/27 1945, at 11-30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/1 1945 to 5/27 1945 and that I last saw him alive on 5/24 1945
Immediate cause of death: Cerebral Hemorrhage — DURATION: 2 Months
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: H. S. Kahlman M.D. M. D. or other
Address: Charlotte Date signed: 5/28/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age is shown on FILM No. G 95 JUN 8 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

T 05446

Reg. Dist. No. 733

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: P. H. Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No.: E. Church St (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Joseph Waller

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Divored

6.(b) Name of husband or wife: Ann Smith Waller
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 20, 1884

8. AGE: Years	Months	Days	If less than one day
50 60	8	19	..... hrs. ..... min.

9. Birthplace: Wicomico co, Md (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business

FATHER
12. Name: Benjamin Waller
13. Birthplace: Wicomico co, Md

MOTHER
14. Maiden name: Matilda Vinalbe
15. Birthplace: Wicomico co, Md

16. Informant: Mrs Harry Roberts
Address: Queen Town Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-11-45 (month) (day) (year)
Cemetery or crematory: Protestent Cemetary
Location: Delmar Del

18. Funeral director: The Hill & Johnson Co
Address: Salisbury Md

19. 5/11, 1945 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 9, 1945 at 8 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 1945 to May 9 1945
and that I last saw him alive on May 9 1945

Immediate cause of death	DURATION
(a) Cerebro vascular	
Due to: rural disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: ..... Date signed .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Letter from Mrs. Julia Varga filmed 12-28-45 G100 changing surname. - LL
Items 6a and b: marr.cer. filmed 9-17-46 G107 LL

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

05444

Reg. Diat. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since Nov. 14, 1941
Hospital, Institution, or street address where death occurred:
Eastern Shore Tuberculosis Sana.
How long in hospital or institution? Since Nov. 14, 1941

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Queen Anne
City or town: Marydel, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.F.D.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Emerick (James) Varga ~~VARGA~~

3.(b) Social Security Number:

4. Sex: Male
5. Color or race: White (Magyar)
6.(a) Single, married, widowed, or divorced: ~~Widower~~ MARRIED
6.(b) Name of husband or wife: Julia Varga ~~VARGA~~ (deceased)
6.(c) If alive, give age: ..... years
7. Birth date of deceased (mo., day, yr.): Sept. 2, 1873
8. AGE: Years: 71 Months: 8 Days: 2 If less than one day: ..... hrs. ..... min.
9. Birthplace: Papan, Hungary (Town, county, and state)
10. Usual occupation: Gardner
11. Industry or business:
FATHER 12. Name: Vendel Varga ~~VARGA~~
13. Birthplace: Hungary
MOTHER 14. Maiden name: Elizabeth Mogyar
15. Birthplace: Hungary
16. Informant: Mrs. Eastern Shore T.B. Sana. Address: R.F.D. Salisbury Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 9-45 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Maryland
18. Funeral director: Hollowy & Walter R. Holloway
Address: Salisbury Md.
19. 5/9/45 (Date rec'd by registrar) Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 4, 1945 at 11:20a M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 14 1941 to May 4 1945 and that I last saw h... 1m alive on May 4 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	4 yrs
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy (If so, state results): .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Injured at work?
23. SIGNATURE: Lewis Olsen M.D. M. D. or other
Address: Salisbury Md. Date signed: 5-5-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-C)

CERTIFICATE OF DEATH

B5447

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH: Wicomico
County
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
1304 N. Division Street
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 117 Fitzgerald St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Louisa Jane White

3.(b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: Benjamin Thomas White
6.(c) If alive, give age: Dead years
7. Birth date of deceased (mo., day, yr.): Oct. 16-1856

8. AGE: Years: 88 Months: 6 Days: 19 If less than one day: hrs. min.

9. Birthplace: R.F.D. Salisbury Maryland (Town, county, and state)
10. Usual occupation: Home keeper
11. Industry or business: at Home

FATHER
12. Name: John Toadvine
13. Birthplace: R.F.D. Salisbury Md.

MOTHER
14. Maiden name: Elizabeth Brown
15. Birthplace: R.F.D. Salisbury Md.

16. Informant: Mrs. Frances Hancock
Address: 117 Fitzgerald St. Salisbury Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 7-1945 (month) (day) (year)
Cemetery or crematory: Parsons Cemetery
Location: Salisbury Maryland.
18. Funeral director: Holloway & C. Walter R. Holloway
Address: Salisbury Maryland
19. 5/7/1945 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 5th 1945, at 3:45 P.M.
I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940 to May 5 1945
and that I last saw h. on alive on May 4 1945
Immediate cause of death: Valvular Heart Disease

	DURATION
Due to: Chronic Nephritis	5 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results.
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did Injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of Injury Injured at work?

23. SIGNATURE: Hunter R Mann M. D. or other
Address Salisbury Md Date signed 5/6/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-a)

05448

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH: Wicomico
County ..... Nanticoke
City or town ..... (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Nanticoke
(If outside city or town limits, write RURAL and give nearest town)
Street No. Near Willing's Home
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Minnie Willing

3. (b) Social Security Number

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: J. Elrick Willing
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): May 25 1866
8. AGE: Years: 79 Months: Days: 4 If less than one day: hrs. min.
9. Birthplace: Cambridge Md.
(Town, county, and state)
10. Usual occupation: Home work
11. Industry or business: at Home
FATHER 12. Name: James Norman
13. Birthplace: Cambridge Md
MOTHER 14. Maiden name: Rachel Blackiston
15. Birthplace: Balto Md
16. Informant: Ora Willing
Address: Nanticoke Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof May 31 1945 (month) (day) (year)
Cemetery or crematory: Private Farm
Location: on Travelling Farm
18. Funeral director: C. P. McIntosh
Address: Princess Md.
19. May 30 1945 (Date rec'd by registrar) R. Wexford Waller Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH May 29th 1945, at 6 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Medical Examiner to Report 19
and that I last saw h alive on 19

	DURATION
Immediate cause of death: Fracture of Skull	sudden
Due to: Fall downstairs	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of May 29 1945
Where did injury occur? Nanticoke (City or town) Wicomico (County) Md (State)
Injured at home, farm, industry, public place (where?) Home
Means of injury: Fall downstairs Injured at work? No

23. SIGNATURE: Chas T. Frisby M.D.
Deputy medical Examiner M. D. or other
Address: Salisbury Md. Date signed 5/31/1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 915

CERTIFICATE OF DEATH

05449

Reg. Diat. No. 330

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Wicomico
City or town Mardela Md R.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Wic
City or town Mardela R.D
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war.

3.(a) FULL NAME Clifton B Wilson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Single

6.(b) Name of husband or wife.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 26 -1911

8. AGE: Years	Months	Days	If less than one day
33	10	20	..... hrs. ..... min.

9. Birthplace Wicomico Md
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business

FATHER
12. Name Garfield T. Wilson
13. Birthplace Md

MOTHER
14. Maiden name Addie Bennett
15. Birthplace Md

16. Informant Addie Wilson
Address Mardela Md R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 5-19-1945 (month) (day) (year)
Cemetery or crematory Mardela
Location
18. Funeral director Grayson Bros
Address Sharptown

19. 5/19/45 (Date rec'd by registrar) W. H. Robertson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/16 1945 at 10-20 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/14 1945 to 5/16 1945
and that I last saw h.. alive on 5/16 1945

Immediate cause of death	DURATION
Uremia	(1½ days 34 hours
Due to interstetial Nephritis acute and pyelitis	6 mos.
Due to	
Other condition Subacute bacterial endocarditis (Include pregnancy within 3 months of death)	6 months

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No.
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE M. D. or Other
Address Cambridge Md Date signed 5/18/45

Dr. Mann

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

CERTIFICATE OF DEATH

T 05450

Reg. Diat. No. 333

1. PLACE OF DEATH: Wicomico
County: Salisbury
City or Town: (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 28 years
Hospital, institution, or street address where death occurred: 107 New York ave
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)
Street No.: 107 New York ave (If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Julia Anne Wilson
3. (b) Social Security Number:

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widow
6.(b) Name of husband or wife: William S. Wilson
6.(c) If alive, give age: Dead years
7. Birth date of deceased (mo., day, yr.): Sept. 10-1869
8. AGE: Years 75 Months 7 Days 28 If less than one day ... hrs. ... min.
9. Birthplace: Mt Vernon Maryland (Town, county, and state)
10. Usual occupation: Home keeping
11. Industry or business: At Home
FATHER 12. Name: John S. Jones
FATHER 13. Birthplace: Mt Vernon Md.
MOTHER 14. Maiden name: Caroline Brewington
MOTHER 15. Birthplace: Mt. Vernon Md.
16. Informant: Mr. Price E. Wilson
Address: 107. New York ave. Salisbury Md
17. Burial (Burial, cremation, or removal? Which?) Date thereof May 10-43 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Md
16. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Md.
19. 5/10/1943 (Date rec'd by registrar) Margaret E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 8 1943 at 8:20 a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 27 1943, to May 8 1943
and that I last saw her alive on May 7 1943
Immediate cause of death: Cerebral Hemorrhage — DURATION: 3 hrs 12 days
Due to: Hypertension — 2 yrs
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Nature of injury: Injured at work?

23. SIGNATURE: John R. Mann M. D. or other
Address: Salisbury Md Date signed 5/10/43

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05451

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? one hour

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 5 months

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Wicomico Co.

City or town: Salisbury Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. 133 Rear

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: Moxine Winder

3. (b) Social Security Number: na

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	a. a.	Single

6.(b) Name of husband or wife: no

6.(c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.): Nov 7 1944

8. AGE: Years | Months: 5 | Days: 28 | If less than one day: hrs. min.

9. Birthplace: Salisbury Md (Town, county, and state)

10. Usual occupation: no

11. Industry or business: no

FATHER — 12. Name: Geo Dutton

13. Birthplace: Wyoming Del

MOTHER — 14. Maiden name: Hale Winder

15. Birthplace: Salisbury Md

16. Informant: Reba Winder

Address: Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: May 7 (month) (day) 1945 (year)

Cemetery or crematory: Public

Location: Salisbury Md

18. Funeral director: James H Stewart

Address: Salisbury Md

19. (Date rec'd by registrar) 5/7/45 Harriet E Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: May 4 1945, at M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 4 1945, to May 4 1945

and that I last saw h[illegible] alive on May 4 1945

Immediate cause of death: Broncho = Pneumonia — DURATION

Duration: one day. C.W.G.P.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: Pneumonic patches both lungs

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address: Salisbury Md Date signed: 5/7/45